**Texas Department of Insurance**
***Division of Workers' Compensation***
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

# *MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION*

## *GENERAL INFORMATION*

**Requestor Name and Address**

HOBERT SMITH MD
P O BOX 6582
MCALLEN TX 78502

**Respondent Name**

TEXAS MUTUAL INSURANCE CO

**Carrier's Austin Representative Box**

Box Number 54

**MFDR Tracking Number**

M4-12-1586-01

## *REQUESTOR'S POSITION SUMMARY*

**Requestor's Position Summary Taken From the Request for Reconsideration Letter dated November 28, 2011:** "The original bill was for $350.00 and was submitted with the W5 Modifier missing on the bill. We were informed by your office that the bill was not going to be paid due to the missing information and we corrected the HICFA on 7-15-11 and faxed it to your office. This was submitted as a corrected bill and not a request for reconsideration. We were instructed that we only needed to refax the corrected HICFA. Your EOB indicates that you reconsidered our bill and again determined that the bill should not be paid. This letter is our first request for reconsideration, and includes the corrected bill and EOB for your review. The faxed correction was submitted in the time limits necessary…"

**Amount in Dispute:** $350.00

## *RESPONDENT'S POSITION SUMMARY*

**Respondent's Position Summary:** "The requestor provided designated doctor services on 3/14/11 and then billed Texas Mutual code 99456-NM…Texas Mutual denied payment because the DWC-69 was not completed and the coding was missing the W5 modifier, both of which are required. The requestor corrected the coding but did not submit a DWC-69. Absent the DWC-69, Texas Mutual could not conclude it was completed…The denial of payment was maintained. The requestor submitted the completed DWC-69 on 7/15/11…past the 95 days required by Rule 133.20. No payment is due."

**Response Submitted by:** Texas Mutual Insurance Company, 6210 E. Highway 290, Austin, TX 78723

## *SUMMARY OF FINDINGS*

| Dates of Service | Disputed Services | Amount In Dispute | Amount Due |
|---|---|---|---|
| March 14, 2011 | CPT Code 99456-W5-NM | $350.00 | $350.00 |

## *FINDINGS AND DECISION*

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

## Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers' compensation specific codes, services and programs provided on or after March 1, 2008.
3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 11, 2011
   - PLEASE ADD W5 WHEN BILLING FOR NOT AT MMI.
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE.

   Explanation of benefits dated April 29, 2011
   - CAC-W1 – WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT
   - CAC-16 – CLAIM/SERVICE LACKS INFORMATION WHICH IS NEEDED FOR ADJUDICATION. AT LEAST ONE REMARK CODE MUST BE PROVIDED (MAY BE COMPRISED OF EITHER THE REMITTANCE ADVICE REMARK CODE OR NCPDP REJECT REASON CODE.)
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 225 – THE SUBMITTED DOCUMENTATION DOES NOT SUPPORT THE SERVICE BEING BILLED. WE WILL RE-EVALUATE THIS UPON RECEIPT OF CLARIFYING INFORMATION.
   - 891 – NO ADDITIONAL PAYMENT AFTER RECONSIDERATION
   - 892 – DENIED IN ACCORDANCE WITH DWC RULES AND/OR MEDICAL FEE GUIDELINE INCLUDING CURRENT CPT CODE DESCRIPTION/INSTRUCTIONS.

   Explanation of benefits dated December 30, 2011
   - CAC-193 – ORIGINAL PAYMENT DECISION IS BEING MAINTAINED. UPON REVIEW, IT WAS DETERMINED THAT THIS CLAIM WAS PROCESSED PROPERLY.
   - 877 – BILL PREVIOUSLY PROCESSED. REFER TO RULE 133.250 REGARDING REQUEST FOR RECONSIDERATION.

## Issues

1. Will the Division address the new issue raised by the respondent in their response to this dispute?
2. Has the Maximum Medical Improvement (MMI) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

## Findings

1. The respondent asserts in their response that the requestor submitted the completed DWC-69 past the 95 days required by Rule 133.20. Per 28 Texas Administrative Code §133.307(d)(2)(B), "The response shall address only those denial reasons presented to the requestor prior to the date the request for MDR was filed with the Division and the other party. Any new denial reasons or defenses raised shall not be considered in the review." Per 28 Texas Administrative Code §133.307(d)(2)(B), this new issue will not be further addressed in this dispute review.
2. The requestor billed the amount of $350.00 for CPT Code 99456-W5-MN regarding a Designated Doctor Examination for the injured worker not being at Maximum Medical Improvement (MMI), therefore no Impairment Rating was performed. Per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00.
3. The respondent has previously reimbursed the amount of $0.00 for CPT code 99456-W5-NM. Therefore, the amount of $350.00 is recommended for reimbursement.

**Conclusion**

For the reasons stated above, the Division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $350.00.

## *ORDER*

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $350.00 plus applicable accrued interest per 28 Texas Administrative Code §134.130, due within 30 days of receipt of this Order.

**Authorized Signature**

| Signature | Medical Fee Dispute Resolution Officer | April 3, 2012<br>Date |
|---|---|---|

## *YOUR RIGHT TO REQUEST AN APPEAL*

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812**.